

**Pregnancy Maintenance Initiative  
Client Satisfaction Survey**

1. Agency Name: \_\_\_\_\_
2. Agency City: \_\_\_\_\_
3. How did you learn about these services?
 

<input type="checkbox"/> Friend/Relative <input type="checkbox"/> Pregnancy Care Provider <input type="checkbox"/> Media (television, radio, newspaper) <input type="checkbox"/> Adoption Agency <input type="checkbox"/> School <input type="checkbox"/> Hospital	<input type="checkbox"/> Brochure from agency listed above <input type="checkbox"/> Church <input type="checkbox"/> Health Department <input type="checkbox"/> Another agency: _____ <input type="checkbox"/> Other, specify: _____
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4. Check the services that you received as a result of your participation with the Pregnancy Maintenance Initiative/Case Management.
 

<input type="checkbox"/> Prenatal Medical Care <input type="checkbox"/> Medical Care (non-pregnancy related) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Client           </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Infant           </td> </tr> </table>	<input type="checkbox"/> Client	<input type="checkbox"/> Infant	<input type="checkbox"/> Adoption Guidance <input type="checkbox"/> Drug/Alcohol Assessment/Treatment <input type="checkbox"/> Domestic Abuse Protection <input type="checkbox"/> Child Care <input type="checkbox"/> Parenting Education/Support <input type="checkbox"/> Transportation
<input type="checkbox"/> Client	<input type="checkbox"/> Infant		
5. How long did you wait for your first visit with the PMI case manager?
 

<input type="checkbox"/> less than 1 week <input type="checkbox"/> 1 week <input type="checkbox"/> 2 weeks	<input type="checkbox"/> 3 weeks <input type="checkbox"/> 4 weeks or more
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6. Did you have problems getting to the services (e.g., transportation, appointments conflicted with work schedule or school, child care)?
 

<input type="checkbox"/> No	<input type="checkbox"/> Yes <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;">           Describe the problem: _____    <hr style="width: 100%; border: none; border-top: 1px solid black; margin-top: 10px;"/> </td> <td style="width: 50%; vertical-align: top;">           _____         </td> </tr> </table>	Describe the problem: _____  <hr style="width: 100%; border: none; border-top: 1px solid black; margin-top: 10px;"/>	_____
Describe the problem: _____  <hr style="width: 100%; border: none; border-top: 1px solid black; margin-top: 10px;"/>	_____		
7. Were the days and times for services good for you?
 

<input type="checkbox"/> No	<input type="checkbox"/> Yes <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;">           What days would have been better for you? _____    <hr style="width: 100%; border: none; border-top: 1px solid black; margin-top: 10px;"/> </td> <td style="width: 50%; vertical-align: top;">           _____         </td> </tr> </table>	What days would have been better for you? _____  <hr style="width: 100%; border: none; border-top: 1px solid black; margin-top: 10px;"/>	_____
What days would have been better for you? _____  <hr style="width: 100%; border: none; border-top: 1px solid black; margin-top: 10px;"/>	_____		
8. On the average, how long did you have to wait before you were seen by the case manager or other staff at this agency?
 

<input type="checkbox"/> less than 15 minutes	<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 31-45 minutes	<input type="checkbox"/> 46 minutes - 1 hour	<input type="checkbox"/> 1-2 hours	<input type="checkbox"/> more than 2 hours	<input type="checkbox"/> not applicable
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9. During your visits:

Did the case manager carefully listen to you?  Yes  No  
Did service providers carefully listen to you?  Yes  No  
Do you feel you participated in the goal planning?  Yes  No  
Were things explained in a way you could understand?  Yes  No

If you checked "no" to any of the above, please explain: \_\_\_\_\_

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10. Did you feel you were fully informed of:

Available services to continue your pregnancy?  Yes  No  
Location of services?  Yes  No  
Requirements of services?  Yes  No  
Length of services during pregnancy and after?  Yes  No

11. If these services had been unavailable, what would you have done in relation to your pregnancy and other needs?

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12. Would you recommend these services to a friend or relative?  Yes  No

13. How old are you?

under 15  15-17  18-19  20-24  25-29  
 30-34  35-39  40-44  45-54  55 or older

14. What is your race?

White  Black or African American  American Indian/Alaskan Native  
 Asian  Native Hawaiian/Pacific Islander  Other

15. Do you consider yourself to be of Hispanic origin?  Yes  No